Government and Medicine I

The Short-Doyle Program

Past, Present and Future

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THE GROWTH OF community psychiatric services in California has paralleled in a general fashion the development of similar services, where they exist, across the nation. California's public, tax-supported community mental health program, however, has become exceptionally active in recent years and shows every sign of continued expansion.

Before catching a bird's eye view of the development of these local mental health services and before discussing nearer than yesterday changes in the community program on a statewide level, let us clearly understand what local mental health services are.

"Community psychiatry" is a broad term encompassing psychiatric services of all types, through private as well as public resources, to a population within a given community.

"Local mental health services" as used in the context of this writing refers to public, tax-supported mental health programs engendered within a community for the benefit of the citizens of the community. Local mental health services are supported, at least in part, by local funds and are traditionally available to a person within a reasonable distance of his family home. Local mental health services are distinct from state mental health services, which are also tax-supported, but which are maintained solely by the State Department of Mental Hygiene in a few large institutions scattered throughout California.

Background of the Short-Doyle Act

Until 1957 most public, tax-supported mental health services were provided in state hospitals and clinics operated by the Department of Mental Hygiene. "Community services" consisted largely of a few private, non-profit clinics and the available reservoir of private psychiatry. Individual psychiatrists and private hospital or clinic staff scattered throughout larger metropolitan communities provided care to citizens who were personally able to afford it and also to some who were not. A great many people unable to pay for the cost of their own treatment, however, ultimately entered a state hospital, either voluntarily or by court commitment.

Although there were several large state hospitals for the mentally ill scattered widely throughout California, many state hospital patients were far removed geographically from their homes during hospitalization. Isolation and mass regimentation which tended to prolong institutional treatment were generally considered undesirable, but seemed more like circumstantial necessities than remediable conditions.

In addition California state hospitals were experiencing a continual growth in patient population. The rate of admission to state hospitals for the mentally ill per 100,000 population, for instance, jumped from 106.6 in the year ended 30

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June 1948 to 139.0 during the year ended 30 June 1953. The overcrowding of state hospitals was becoming strikingly distressing. By the early 1950's the rate of growth for the mentally ill resident population in California state hospitals was close to 1,000 additional occupied beds per fiscal year. The prospect of adding 1,000 new beds each year throughout the state hospital system seemed to portend nothing but continual overcrowding of existing hospitals or the eventual construction of large new state hospitals as the population continued to grow.

It was during the years between 1950 and 1955 that legislators, responsible citizens and citizen associations, and the medical and psychiatric professions themselves began an intensive planning effort aimed at stemming the tide of state hospital growth, and also at hopefully eliminating some of the admittedly negative aspects of state hospital-type treatment. After considerable study on the part of such groups as the California Medical Association and the County Supervisors Association, a system for providing local mental health services was endorsed by the Department of Mental Hygiene and planned as a legislative proposal.

Although the proponents of the newly envisioned system of local mental health services believed at one point that they had cleared all legislative obstacles in 1955, it was not until 6 July 1957 that the bill was signed by the Governor and thereby enacted into law. Known as the Short-Doyle Act after Senator Alan Short and Assemblyman Donald Doyle, who guided it through the legislature, the new law provided a legal instrument or mechanism permitting local communities to develop mental health services through the use of state funds if they chose to do so.

Nature of the Short-Doyle Program

What is the Short-Doyle Act? What does it provide? And how did it effect changes in the total mental health and community mental health fields in California?

Basically the Short-Doyle Act provides state funds to be matched by local funds for the development of psychiatric and other mental health-related services at the local level. The community body appropriating funds for mental health services is usually County Government, although a few Short-Doyle city programs did develop following the passage of the Act.

The original state-local matching formula was 50-50; whatever sum the county (or city) appropriated for local mental health services, less fees, insurance and other minor charges, was exactly matched by the state and paid to the county under a reimbursement plan. The program of mental health services developed in any county, then, was partly financed by the county and partly by the state.

During the 11 years since the Short-Doyle Act became effective, legislative action has altered the state-local matching formula in favor of the county. A bill recently signed by the Governor during the 1968 Legislative Session provided for a 75 percent-25 percent matching formula for all Short-Doyle services, the state share being 75 percent and the county's 25 percent.

A local mental health program, commonly called a Short-Doyle program, is under the direction of a local mental health director who is a physician and frequently a psychiatrist. The program is locally based and locally operated, with the director and his staff being employees of the county or city whose population is served by the Short-Doyle program. However, since the state defrays a large portion of the expenses, the state, through the Department of Mental Hygiene, also maintains a regulatory control over the program.

The Short-Doyle Act specifically designated the type of mental health services that could be locally provided under the Short-Doyle plan. The original services, which were five in number, will be expanded to ten through the action of another remarkable piece of legislation to be discussed later. The five original services, which are still technically operative, are as follows:

1. Psychiatric outpatient treatment.
2. Psychiatric inpatient treatment in a general hospital or in a psychiatric hospital affiliated with a general hospital.
3. Rehabilitative services for the psychiatrically disabled.
4. Consultation by qualified mental health personnel to the professional staff of public and private agencies in the community.
5. Mental health information and education services to the public and to key professional groups.

Professional staffing of county Short-Doyle programs in California tends to follow the traditional mental health professional team concept of psychiatrist-psychologist-social worker, although psychiatric nurses, public health nurses, vocational rehabilitation therapists, student professional as-

sistants and other categories of personnel are also commonly hired. Inpatient wards are most frequently located in county hospitals, although several large programs maintain multiple contracts with private hospitals for services to Short-Doyle patients.

A county Short-Doyle program is frequently operated through the county hospital or through numerous hospitals, clinics and professional resources of a private nature in the community. In heavily populated counties with sophisticated Short-Doyle programs, services are usually diffused through the community and may be located in any number of buildings along a cross section of town. In addition to the psychiatric wards at the county hospital, for instance, the San Francisco County Short-Doyle program maintains contracts with nine distinct community agencies, and during fiscal year 1966-67 channeled 3,130 patients through these private resources.

Federal legislation originally passed by Congress in 1963 provided for the construction and staffing of community mental health centers, thus giving further impetus to the expansion and diffusion of mental health services in metropolitan communities. Several modern community mental health centers have been constructed with state, federal and local funds and then staffed and administered by the local Short-Doyle program. Santa Clara County alone has dedicated three new mental health centers in very recent years.

Sparsely populated rural counties, of course, experience entirely different problems from those of large metropolitan areas, and the rural Short-Doyle program tends to show a somewhat different complexion. Low tax bases, remoteness and lack of professional mental health personnel resident in the community have forced considerable ingenuity in establishing practical and efficient programs that fully meet the population's needs. Many of these rural Short-Doyle programs have contracted with neighboring counties for part-time services, or for the services of travelling clinical teams.

The reader may wonder whether counties and cities are able to develop local mental health services without also establishing a Short-Doyle program. Strictly speaking, it is entirely possible, but practically speaking the financial provisions of the Short-Doyle Act have, in effect, all but assured that local mental health services in California would develop through the state-county Short-Doyle plan. There is little incentive for a county to undertake the full expense of a local mental health program if it can receive reimbursement for 75 percent of the cost. While there are occasional incidents where small citizen groups express distrust of state involvement in local affairs, the Short-Doyle program in California has not generally proved unpalatable to counties, for there are many liberal provisions for local option and control.

TABLE. 1.—*Growth of the Short-Doyle Program*

Short-Doyle Appropriations	*Fiscal Year*	*Admissions of Patients to Short-Doyle Programs*		
		Inpatient Services	*Outpatient Services*	*Rehabilitation Services*
$ 3,130,500	1961-62	7,445	15,459	1,301
3,225,000	1962-63	9,763	22,848	1,643
5,450,000	1963-64	22,562	32,869	2,823
11,679,948	1964-65	37,224	49,355	2,884
14,811,727	1965-66	39,681	71,050	4,371
18,600,733	1966-67	41,601	81,294	6,292
24,801,030	1967-68	42,053	93,888	8,585

Growth of Community Mental Health Services in California

Local public mental health services grew very rapidly after the passage of the Short-Doyle Act. During the first fiscal year following its adoption seven local governing bodies made application and received reimbursement for community mental health programs established in accordance with the Short-Doyle Act. These programs became known as Short-Doyle programs, and each of them provided at least two of the five services described earlier. Table 1 shows how rapidly community mental health services have developed in California, both in dollars invested and in the number of patients reached through the community approach.

The total Short-Doyle program in the State of California, all county and city members considered, has grown with particular swiftness in the last five or six years. In 1962, for example, there were 20 Short-Doyle programs. Five years later there were 40. All but three counties with a population over 50,000 have established Short-Doyle services; and even some sparsely populated northern counties not technically considered Short-Doyle providers have broken ground for the development of local mental health services in the very near future, primarily through contractual agreements with adjacent counties or with travelling clinical teams.

All county Short-Doyle programs have developed outpatient treatment services. In addition, about 62 percent of existing Short-Doyle pro-

grams maintain inpatient services, frequently in wards of the local county hospital or in private hospitals through contractual agreements.

Implications of Change

The Short-Doyle Act was originally designed with the objective of establishing mental health services which would be available to the citizen near his home. At the signing of the Short-Doyle Act many progressive leaders in the mental health field considered the ideal course of treatment for a mentally ill patient to be similar to that for any person who had a medical problem. If the nature of the patient's disease is such that he can be successfully treated through prescription drugs and a schedule of outpatient visits to the physician or clinic, it would generally be inappropriate to insist that he be put into a hospital. Only if the disease or difficulty becomes critical or reaches a point where admittance to a hospital is strongly indicated, need the patient prepare for reception in a hospital ward.

Leaving that relatively small group of patients who are dangerous out of consideration, why should treatment for an individual whose illness is primarily "mental" be different from treatment for patients with other medical problems? For practical reasons, however, so long as the only public supported psychiatric inpatient services were located in state hospitals, treatment near home was not always feasible, especially for the patient unable to pay.

It can be fairly stated that the rise of mental health services at the community level has played the most important role in opening the door to psychiatric hospitalization near home. Other factors have entered the picture, such as the advent of Medi-Cal and the liberalization of certain hospital insurance plans, but these developments in relation to the Short-Doyle program have acted as sources of encouragement, facilitating the flow of patients into the system itself.

The effect of the growth of Short-Doyle programs on state hospital population figures is not entirely clear. Correlational studies*, however, would seem to indicate that the emergence of community services, particularly inpatient services, has had a definite bearing on the reduction of first admissions to state hospitals.

*Ferdun, Gareth, On the Impact of Short-Doyle, California Data, 1(2):54-75, Aug.-Sept. 1967.

Recent Developments

The rapid development of local mental health programs and the change in patterns of hospitalization naturally led to further intensive studies of public mental health services and to revisions in the law affecting the statewide Short Doyle program.

The California Mental Health Act of 1967 was the direct result of a two-year legislative interim study on the commitment procedures for mentally disordered patients to California state hospitals. The first part of the act, known as the Lanterman-Petris-Short Act, revised California commitment laws and provided a new course for the involuntary care and treatment of certain classes of mentally disordered patients*. The second part, which is of specific interest to us here, revised the old Short-Doyle Act in a number of significant ways. This part which we may refer to as the Revised Short-Doyle Act was further refined by legislative action during 1968.

The new Short-Doyle Act will not be completely implemented until 1 July 1969, but its salient features can be summarized as follows:

1. Each county with a population over 100,000 is required to establish a community mental health program to cover the entire area of the county. The present law is permissive and allows the county to develop a Short-Doyle program at will.

2. The Short-Doyle mechanism will still remain the instrument by which a county may receive state aid for the development of community mental health services. The reimbursement formula is changed, however, from 75 percent-25 percent to 90 percent-10 percent, the state share being 90 percent and the county share 10 percent. While county Short-Doyle programs will be reimbursed a greater amount of money by the state, they must purchase state hospital care for mentally ill residents of the county (except the judicially committed) with these funds.

3. Local Short-Doyle programs and state hospital services to mentally disordered county patients will therefore be coordinated into a single system of care. The county Short-Doyle program will be responsible for the provision of all public mental health services to residents of the county, utilizing county facilities when feasible and con-

*Editor's note: See page 403 for Brickman, H. R.: California's Short-Doyle Program: The New Mental Health System—Changes in Procedure; Implications for Family Physicians, Calif. Med., 109:403-408, Nov. 1968.

tracting with nearby state hospitals for services when necessary.

4. In order to provide a basis for reimbursement and to avoid duplication and fragmentation of effort, the law will require every county to develop a plan outlining the services it wishes to establish on a priority basis. This county Short-Doyle plan must receive the approval of the Department of Mental Hygiene before the state will reimburse the county 90 percent of the cost of community mental health care. It is intended that the county plan include the fullest possible participation of all existing private and public resources within the county.

5. The number and kind of mental health and mental health related services that a county Short-Doyle program may include and for which it may receive 90 percent reimbursement from the state will be expanded from the present five to ten. These services are:

1. Inpatient services;
2. Outpatient services;
3. Partial hospitalization services, such as day care, night care, weekend care;
4. Emergency services 24 hours per day available within one of the three services listed above;
5. Consultation and education services available to community agencies and professional personnel and information services to the general public;
6. Diagnostic services;
7. Rehabilitative services, including vocational and educational programs.
8. Pre-care and after-care services in the community, including foster home placement, home visiting and half-way houses;
9. Training;
10. Research and evaluation.

A quick comparison of these ten new services with the five services outlined in the original Short-Doyle Act will show that a more comprehensive program and a greater variety of treatment measures will soon be possible. Inpatient psychiatric treatment, for instance, is no longer restricted to the setting of a general hospital or a psychiatric hospital affiliated with a general hospital. It is hoped that local mental health programs will be able to utilize this new flexibility in the fuller development of psychiatric treatment patterns, particularly the provision of immediate crisis intervention.

As indicated earlier, public mental health services, particularly at the county level, have experienced a remarkable growth in the last ten years. The California Mental Health Act of 1967, as revised in the 1968 legislative session, can be reasonably expected to create further impetus to the development of these programs, with many far-reaching implications.